of Tennessee

MAY 2025

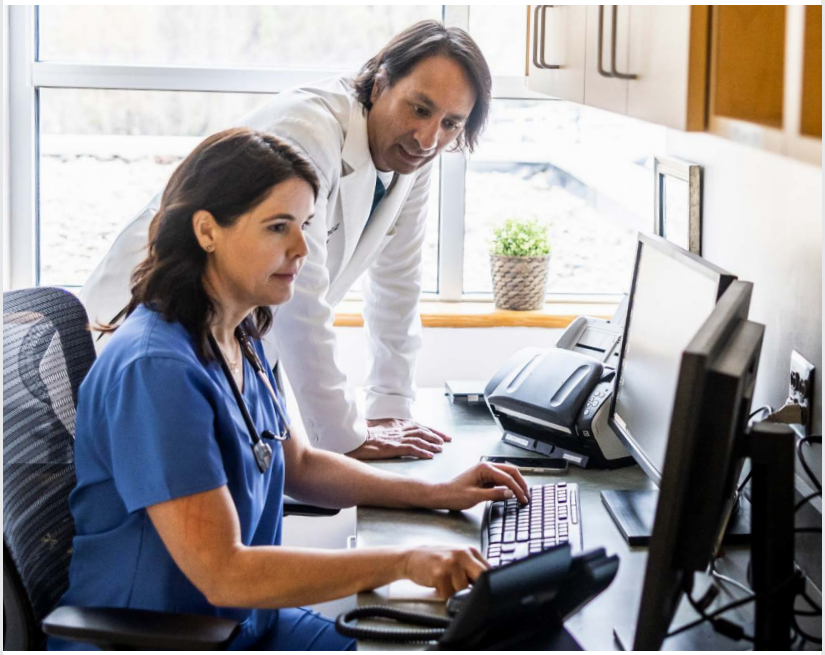
BlueAlert℠

of Tennessee | Mission driven FOR 75 Years

A monthly newsletter for our provider community, featuring important updates and reminders about our company's policies and procedures. All information is broken out by line of business.

BlueCross BlueShield of Tennessee, Inc.

This information applies to all lines of business unless stated otherwise.



Coming Soon: New Reconsiderations and Appeals Tool in Availity®

We're excited to announce our new online reconsiderations and appeals tool will launch later this year. The tool will be available in Availity. Today, providers submit reconsiderations and appeals by phone, fax, mail and email. This new tool will streamline that process.

Want to be an early adopter? Let us know by contacting your **eBusiness Regional Marketing Consultant**.

INSIDE THIS ISSUE

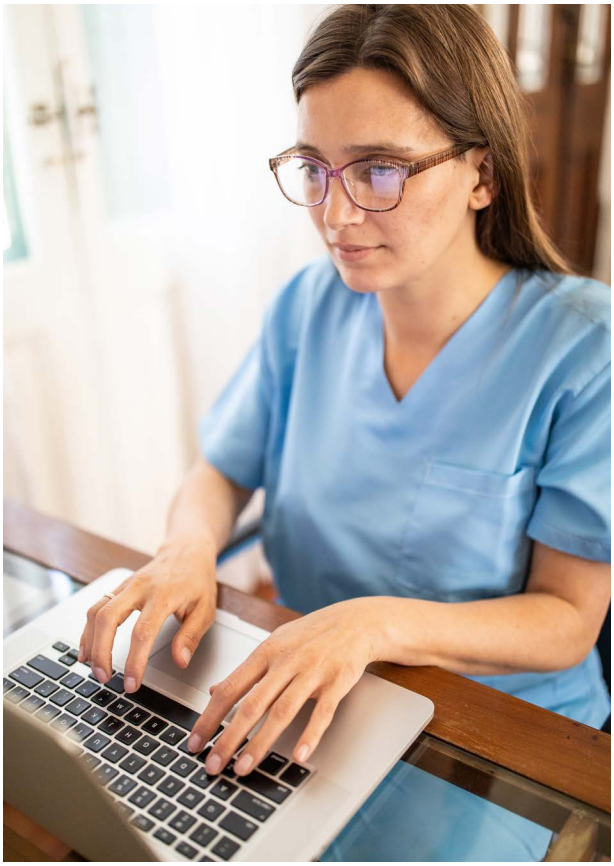
Find Your Authorizations Faster

You can save time and avoid phone calls by quickly checking an authorization status in Availity. The process is easy:

1. Log in to **Availity**.
2. Click on **Payer Spaces** and choose the **BlueCross logo**.
3. Choose the **Authorization Submission/ Review** application.
4. Go to the **Auth Inquiry/Clinical Update** drop-down arrow, then choose **BCBST**.
5. Choose the **case ID number** to see the latest status.

We're no longer faxing authorization status letters, but you can view and print them from here. After choosing the case ID number, look for the letter section in the upper right to view and print the authorization letters.

If you have questions, please call **(423) 535-5717, option 2**, or contact your **eBusiness Regional Marketing Consultant**.



Upcoming Provider Administration Manuals Delayed

To meet operational needs, we're delaying the release of the Provider Administration Manuals (PAMs) for the third quarter (July, August and September) for all lines of business. We'll publish the third quarter PAMs on July 15, 2025. Providers in our Commercial networks will be able to view their Commercial Preview PAM for the third quarter on May 15.

We appreciate your patience.

Taxonomy Code Reminder

As a reminder, professional claims need a taxonomy code (unique 10-character code that designates your classification and specialization) to be submitted for billing and rendering providers. The **National Plan and Provider Enumeration System (NPPES)** directory shouldn't be the single source of determining the correct taxonomy.

It's important that both the billing and rendering provider taxonomy codes match how you're credentialed and contracted with us. For example, if you have a pharmacy, specialty pharmacy or DME provider contract, you'll need to file with the specific taxonomy indicated for each contracted service. If you don't submit the appropriate taxonomy codes, your claims may be rejected or denied or result in reduced reimbursement.

Please be sure to file the two-digit qualifier with taxonomy.

About the Provider Exclusion Screening Process

The health and safety of our members and your employees are important, which is why we'd like to remind you of your contractual obligation to screen all employees, agents and contractors (the "Exclusion Screening Process") against the exclusion lists.

You also need to conduct criminal background checks and registry checks in accordance with state law to determine whether any of them are "ineligible persons," and therefore, excluded from participation in the Medicare or Medicaid programs. At minimum, registry and exclusion checks must include the Tennessee Abuse Registry, Tennessee Felony Offender Registry, National and Tennessee Sexual Offender Registry, Social Security Death Master File, HHS-OIG List of Excluded Individuals and Entities (LEIE), System for Award Management (SAM), and the Tennessee Terminated Providers List.

The screenings should be conducted prior to hiring employees or contracting with individuals and entities, and every month following. Providers are also required to have employees and contractors disclose if they're ineligible persons prior to providing any services on behalf of the provider.

If you have questions, please refer to the "Provider Networks - Federal Exclusion Screening Requirement" section of the **BlueCross BlueShield of Tennessee** and **BlueCare Tennessee Provider Administration Manuals**.

Change of Ownership Requirements

Anyone acquiring a provider facility or group must give us at least 60 days advance notice of change of ownership (CHOW). If you're acquiring more than 25% control of a provider facility or group, you also need to submit a CHOW notification using the **Provider Change of Ownership Notification Form**. Once the transaction has closed, send us a copy of the executed bill of sale or purchase document (minus the purchase price) within five business days of closing. If you don't provide the required notice or documents, your payments could be impacted.

A CHOW is defined as:

- Direct or indirect sale or other disposition of all or a majority of the assets of a provider;
- Any transaction resulting in a change in the beneficial owner, directly or indirectly, of more than 25% of the then-outstanding number of units, interests or shares of the provider's voting stock (or membership interests or other equity);
- Conversion – Changing from one legal entity type to another (i.e., conversion from partnership to corporation or conversion from corporation to a limited liability company);
- The lease of all or part of the provider's facility; or
- Any other transaction that results in a change to the NPI or Tax ID of a provider.

You can find additional information in the Frequently Asked Questions document **here**.

Save the Date – 2025 All Blue Workshop℠

On **Thursday, Aug. 14, 2025**, we're hosting our annual All Blue Workshop. Join us for an all-day virtual event where we'll discuss the latest news, updates and topics important to you and your practice. You can also ask questions about working with BlueCross. Registration opens soon. Be sure to look for more information in future BlueAlert issues. We look forward to seeing you online.

Inclusive or Exclusive Billing for Behavioral Health Psychiatric Facilities

Please review the following guidelines for institutional and professional providers to ensure you're billing for inclusive services correctly.

Institutional providers (psychiatric hospital, residential treatment center, other psychiatric outpatient facility)

Your contract with us includes details about inclusive or exclusive service billing. You can find information under each section of your contract addressing your rates for each service, such as inpatient, intensive outpatient and partial hospitalization.

If the language about the rate for a particular service denotes it as inclusive, all professional or physician services must be provided as part of that rate. You shouldn't submit another claim for professional or physician services rendered in your facility as part of the service you're providing. Please ensure providers supporting these services are aware of the inclusive agreement.

Professional providers (psychiatrists, nurse practitioners, psychologists, therapists, primary care physicians)

When providing services at a psychiatric hospital, residential treatment center or other psychiatric outpatient facility, please confirm with the facility if professional services should be billed separately. If you're providing services at a facility whose rates are inclusive of professional services, you can't file a separate claim. Any amount we pay you for your service with this facility is subject to an overpayment recovery.

If you have questions, please contact your Provider Network Manager.

Commercial

This information applies to Blue Network P℠, Blue Network S℠, Blue Network L℠ and Blue Network E℠ unless stated otherwise.

Billing Guidelines for Hospice Services

If you've experienced any problems submitting claims for hospice services, you can use the following information to help make sure the process goes smoothly:

- Bill using an institutional claim form.
- Bill a separate line item for each date of service.
- Match the total days billed on the inpatient care with the from/through dates on the statement.
- Use Type of Bill (TOB) 081X or 082X in Form Locator 4 if the inpatient and outpatient services are on separate claims.
- Make sure the TOB determines the Place of Service (POS).
  - Inpatient per diem is only reimbursed when a patient dies in a hospice facility. If a patient dies at home, the POS should be home, not the hospice facility.
- Hospice discharge date is eligible for payment and won't be considered as an exclusion.
- Make sure the discharge status reflects where the patient died.
- Bill with the hospice provider number and/or NPI referenced in the network attachment.
- Reimbursable allowable rate per unit will be rounded up to the second decimal amount (e.g., $8.7110 would be $8.72).
- In all cases, reimbursement for hospice services is based on:
  - Per diems allowed on a per day basis only.
  - The lesser of total covered charges or maximum allowable hospice fee schedule.

If you have any questions about billing for hospice services, please contact your Provider Network Manager.

Out of State (BlueCard) Authorizations

Out of state providers seeking prior authorization for our members can submit requests electronically through their normal provider portal. You can access the authorization from your local Blue Plan portal like you would for an in-state authorization. If the Blue Plan uses **Availity**, you can submit the authorization there by clicking on the **Authorization & Referrals** link. If a Blue Plan uses a different portal for authorizations, you should start the request on that portal.

To streamline the process and prevent the authorization from being delayed, please enter the ordering/requesting provider information and complete all necessary fields.

Controller Medication Adherence for Asthma Patients Can Improve Symptoms

May is National Asthma and Allergy Awareness Month. Almost 28 million people in the U.S. have asthma. Ensuring patients with asthma use their controller medications properly can help them better manage their symptoms.

The Asthma Medication Ratio (AMR) is a HEDIS® measure that examines the ratio of controller medications to total asthma medications for patients 5-64 years old with persistent asthma. A ratio of 0.50 or higher during the measurement year indicates better asthma control for these patients, since it reflects consistent use of controller medications.

Try these strategies to improve asthma medication adherence for your patients:

- **Educate patients on the importance of daily use of asthma controller medications.** Some patients need help understanding the difference between long-acting controller and rescue medications.
- **Consider prescribing 90-day supplies of controller medications.** Be sure at least half of asthma medications dispensed during the treatment period are controller medications.
- **Schedule regular follow-up visits to monitor asthma control and adjust treatment.** Use these visits to address barriers to medication adherence where possible.

HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

Save Time With High Tech Imaging Prior Authorizations

Please find out if your patients have High Tech Imaging (HTI) prior authorization requirements before starting the authorization process. Not all our Commercial plans require HTI authorization and checking on this can save you some time.

You can check when you log in to Availity to verify patient benefits. Just click the blue button labeled **Prior Authorization Requirements**, then look for the **High-Tech Imaging** category. If **Yes** is listed, an authorization is required, and you should continue with the process. If **No** is listed, an authorization isn't required.

If you have questions, please call **(423) 535-5717, option 2**, or contact your **eBusiness Regional Marketing Consultant**.

Upcoming Prior Authorization Changes

You can easily find the latest changes to prior authorizations under Upcoming Prior Authorization Changes in the News & Updates section of our **Documents & Forms** page. Prior authorization changes are published at least 60 days before the effective date. If you have questions, please call us at **1-800-924-7141** and follow the prompts for providers **(option 1)**.

BlueCare Tennessee

This information applies to BlueCare℠, TennCareSelect and CoverKids plans unless specifically identified below.

Provider Initiated Notice (PIN) Forms Can Be Submitted in Availity

PIN forms for applied behavior analysis therapy providers can now be submitted through the Prior Authorization application in Availity's Payer Spaces section. To submit PIN forms, follow these steps:

1. Log in to **Availity**.
2. Click **Payer Spaces** and go to the **BlueCross logo** icon.
3. Choose the **Authorization Submission/ Review** application.
4. Click on **Auth Inquiry/Clinical Update** and search for **Existing Authorization**.
5. PIN forms can be submitted into the clinical update section of the authorization.

If you have questions, please call **(423) 535-5717, option 2**, or contact your **eBusiness Regional Marketing Consultant**.

Checking in on Children's Mental Health

May is Mental Health Awareness Month. Children's mental health affects their ability to have a high quality of life. And yearly Early and Periodic Screening, Diagnostic and Treatment (EPSDT) visits are a great time to check in on your patients' mental health.

Mental health screenings during EPSDT visits let you check in on your patients' development and emotional health. If you note any areas of concern, you can talk about them with your patients' parent or guardian.

The CDC says the most common mental health conditions for children are anxiety disorders, depressive disorders and behavior disorders. These conditions are often long-term, but treatment can help your patients better manage their mental health.

You can find more information about EPSDT visits and starting conversations with parents and guardians in our **EPSDT Partners In Prevention booklet**.

Save the Date for Our June 2025 EPSDT Virtual Workshop

We're hosting our first EPSDT virtual provider workshop of 2025 on **June 12** from **noon-1:30 p.m. ET**. Please plan to join us. We'll share more event and registration details soon.

Note: The information in this article doesn't apply to CoverKids.

Talk About Preeclampsia With Your Pregnant Patients

May is Preeclampsia Awareness Month and a good time to talk with your expecting patients and their families about preeclampsia. Preeclampsia and other hypertensive disorders affect 5–8% of all pregnancies and can develop quickly. Talking to patients early can better prepare them and improve outcomes if they do develop preeclampsia.

Discuss these topics with your pregnant patients:

- Explain how preeclampsia can cause serious complications during pregnancy and after birth.
- Encourage patients to attend all scheduled prenatal visits to identify blood pressure changes early.
- Review preeclampsia risk factors with patients, including:
  - Medical conditions such as chronic high blood pressure, diabetes, kidney disease and autoimmune conditions
  - Family history and age
  - Body mass index (BMI)
  - Race and ethnicity
  - In vitro fertilization
- Educate patients about the warning signs of preeclampsia so they can seek care quickly:
  - Swelling in the face, legs or hands
  - Severe or persistent headache
  - Vision changes
  - Sudden weight gain
  - Difficult breathing
  - Nausea and vomiting during the second half of pregnancy
  - Pain in the upper abdomen or shoulder
  - Dizziness

Rapid Whole Genome Sequencing Coverage for BlueCare Tennessee Members

BlueCare Tennessee offers coverage and reimbursement for Rapid Whole Genome Sequencing (RWGS) as medically necessary. We cover it as a separately payable service for our members who meet the following clinical criteria:

- The member is younger than 21.
- The member has a complex or acute illness of unknown etiology that isn't confirmed to be caused by an environmental exposure, toxic ingestion, trauma or an infection with a normal response to therapy.
- The member is receiving hospital services in an intensive care unit or another high-acuity care unit in a hospital.

Preliminary results for RWGS are available within seven days of the date the lab receives the sample. The final results are available within 15 days. We don't require prior authorization for RWGS.

Requesting reimbursement

Please use these codes when requesting reimbursement for RWGS:

- **0425U-Genome** (e.g., unexplained constitutional or heritable disorder or syndrome), **rapid sequence analysis, each comparator genome** (e.g., parents, siblings)
- **0094U-Genome** (e.g., unexplained constitutional or heritable disorder or syndrome), **rapid sequence analysis**

Process Review: Medicare and Dual-Special Needs Plan (D-SNP) Crossover Claims

As of **Jan. 1, 2024**, we process crossover claims. These claims cross over from Medicare or a D-SNP so we can process the Medicare/D-SNP copay, coinsurance and deductible (cost-share amount). Previously, the Division of TennCare processed these claims.

Crossover claims should cross over to us automatically from Medicare or your patient's D-SNP for us to process the applicable cost-share amount. If your patient also received Medicaid-covered services not covered by Medicare or a D-SNP, please submit a secondary claim to us for those services.

When filing crossover and secondary claims for Medicare or D-SNP services, please keep this information in mind:

- TennCare assigns all Qualified Medicare Beneficiary-only (QMB-only) members to TennCare*Select* to process their Medicare/D-SNP cost-share amounts only. These claims should cross over automatically from Medicare or a D-SNP. Individuals in the QMB-only eligibility category don't have Medicaid benefits. If providers submit secondary claims for Medicaid services for these members, we'll deny those claims.
- Continue to submit claims with dates of service before Jan. 1, 2024, to TennCare. For these claims, TennCare will process the Medicare/D-SNP copay, coinsurance and deductible amount. Then, bill us for any remaining Medicaid-covered services.
- Please allow at least **60 days** from the **Medicare or D-SNP paid date** for the claim to cross over to us before filing a claim for us to process the Medicare/D-SNP cost-share. If a claim doesn't cross over as expected, please call the Provider Service line for your patient's plan for next steps:

BlueCare **1-800-468-9736**

TennCare*Select* **1-800-276-1978**

CoverKids **1-800-924-7141**

For more information about the Medicare/D-SNP crossover process, please review our **Medicare Crossover Claims FAQs**.

How You Can Support Foster Parents Considering Adoption

Do you work with patients in the Select*Kids* program? You can help support foster parents thinking about adoption. Here's how:

- **Get to know the process.** Familiarize yourself with the adoption steps. You can learn about the process on the Tennessee Department of Children's Services website.
- **Offer emotional support.** Listen to the concerns of the foster parents and child. Offer resources and/or a referral to a behavioral health specialist or family counselor who can support them during this transition.
- **Refer them to us.** Do they have questions about how their child's health coverage may change? We're here to help. Foster families can contact Select*Kids* at **1-888-422-2963**. They can also visit our foster parents support page.

Note: The information in this article only applies to TennCare*Select*.

At-Home Blood Pressure Cuffs Available for Pregnant and Postpartum Patients

At-home blood pressure monitoring during pregnancy and the postpartum period is beneficial for managing a variety of health conditions. Regular monitoring aids in early detection of complications, helps facilitate timely intervention and empowers patients to actively participate in their care.

Pregnant and postpartum patients with BlueCare, TennCare*Select* and CoverKids coverage can now get at-home blood pressure cuffs to monitor their health.

To obtain a blood pressure cuff for your patient, submit a completed order to an in-network durable medical equipment (DME) provider. Prior authorization isn't needed. The DME provider will bill us directly with an appropriate pregnancy-related diagnosis and supply the cuff to the patient. While you can use any in-network DME provider, preferred vendors include Home Care Delivered®, Aeroflow, and Byram® Healthcare.

Your Source for Division of TennCare Announcements

You can view announcements from TennCare in the **News and Updates** section of **bluecare.bcbst.com/providers**. These announcements replace the TennCare Provider Experience newsletter. We'll update them quarterly, so check back frequently for news you need.

BlueCare Tennessee and BlueCare Plus Tennessee

This information applies to both BlueCare Tennessee and BlueCare Plus Tennessee lines of business.

Update to Billing Requirement for Professional Claims

In the **April 2025** BlueAlert newsletter, we published an article stating that we'd soon begin applying claims edits to BlueCare Tennessee and BlueCare Plus Tennessee claims if the referring provider's NPI is the same as the billing or rendering provider's NPI.

We're no longer implementing this claim edit. Please disregard any information included in the previous article.

BlueCare Plus Tennessee

This information applies to our Medicare and Medicaid dual-eligible special needs plans unless specifically identified below.

Acute Inpatient Stay Approvals

Acute inpatient stays are reviewed for medical necessity, and approval covers the entirety of the member's diagnosis-related group (DRG) stay. Approval also covers the DRG payment. Outlier payments may be subject to retrospective claims review. **Note:** Extended stay or concurrent reviews on admissions don't need to be submitted for admissions dates on or after Oct. 16, 2024.

2025 Special Needs Plan Model of Care (MOC) Training Now Available

Providers participating in BlueCare Plus Tennessee special needs plans are contractually required to complete our MOC training after initial contracting, then every year afterward. This training promotes quality of care and cost effectiveness through coordinated care for our members with complex, chronic or catastrophic health care needs. You can access the online self-study training and attestation by **clicking here**.

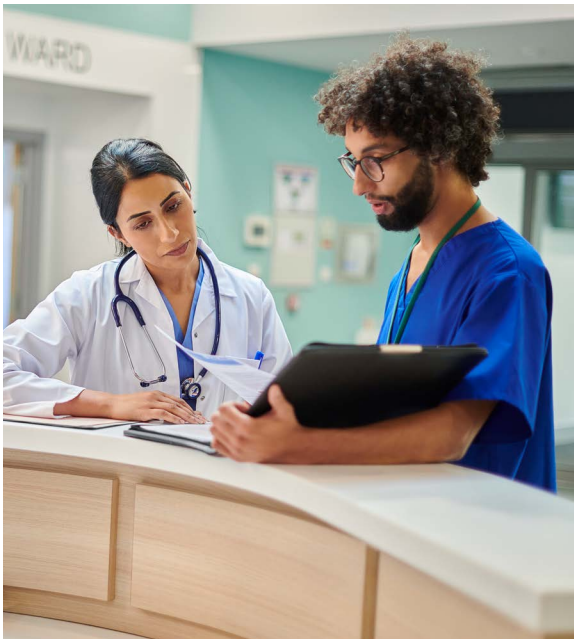
BlueCare Plus Tennessee and Medicare Advantage

This information applies to both BlueCare Plus Tennessee and Medicare Advantage lines of business.

Facility Reimbursement for Readmissions After May 1, 2025

Facilities will be reimbursed for a single inpatient DRG payment for readmissions occurring on or after **May 1, 2025**. Separate reimbursement for subsequent inpatient readmission claims isn't appropriate and won't be recognized. This applies to readmissions subject to our 31-Day Same or Similar-Cause Readmission Quality Program. Only readmissions occurring as an acute inpatient admission to the same or similar facility or facility operating under the same contract are included in this program.

The Provider Administration Manual will be updated with this change.



Master Prior Authorization List Review and Upcoming Updates

In preparation for the 2025 Centers for Medicare & Medicaid Services (CMS) proposed rule changes related to prior authorization (PA), we're reviewing the **Master Prior Authorization List** to identify opportunities to reduce the number of services requiring prior authorization.

Effective **April 1, 2025**, we've removed the PA requirements from more than 3,000 codes. Many of those codes are related to durable medical equipment, orthotics and prosthetics, and CPT® codes identified on the CMS inpatient only code list (inpatient admission still requires PA).

We've created a **Master Prior Authorization List Code Removals** document with all codes that no longer require PA. You can find the most up-to-date lists on our **Authorizations and Appeals** provider site.

Medicare Advantage

This information applies to our BlueAdvantage (PPO)℠ plans unless specifically identified below.

Faster Decisions for Medicare Advantage Prior Authorizations

Looking to fast track authorizations? Many authorizations can be approved automatically if you choose the appropriate Local Coverage Determination guideline when submitting clinical information. Choosing the first guideline that appears can cause the authorization to pend for nurse review, delaying your approval. Try using the LCD guidelines when appropriate. If your request meets all the criteria, you may get instant approval. If you have questions, please call **(423) 535-5717, option 2**, or contact your **eBusiness Regional Marketing Consultant**.

Quality Care Initiatives

This information applies to all lines of business unless specifically identified below.

THCII Episodes of Care Quarterly Report Release

New quarterly reports for Medicaid and Commercial Episodes of Care Quarterbacks will be available May 15, 2025. If you're having trouble accessing your quarterly report, please call **(423) 535-5717** and press **option 2** or email **eBusiness_Service@bcbst.com**.

Note: This article only applies to providers in our BlueCare and Commercial networks.

Pharmacy

This information applies to all lines of business unless specifically identified below.

Refer to the TennCare Pharmacy Benefit Manager for Important Updates

Please **click here** to review important notices about prescribing changes, authorization guidelines and other items related to the TennCare Pharmacy Program.

Tips for Coding Professionals

This information applies to all lines of business unless specifically identified below. Please note these tips are educational only. Providers remain responsible for completion of claims submitted to BlueCross.

Coding Updates: See the Latest and What Changes Are on the Way

You can easily find current coding updates and pending claim edit changes under **Coding Updates** in the Coding Information section of our **Coverage & Claims** page. You can access code edits 60 days before the effective date. If you have questions, please call us at **1-800-924-7141** and follow the prompts for providers **(option 1)**.

BlueCross BlueShield of Tennessee, Inc., BlueCare Tennessee and their licensed health plan and insurance company affiliates comply with the applicable federal and state laws, rules and regulations and does not discriminate against members or participants in the provision of services on the basis of race, color, national origin, religion, sex, age or disability. If a member or participant needs language, communication or disability assistance, or to report a discrimination complaint, please, call **1-800-468-9698** for BlueCare, **1-888-325-8386** for CoverKids or **1-800-263-5479** for TennCare*Select*. For TTY help call **771** and ask for **1-888-418-0008**.

This information is educational in nature and is not a coverage or payment determination, reconsideration or redetermination, medical advice, plan pre-authorization or a contract of any kind made by BlueCross BlueShield of Tennessee, Inc. or any of its licensed affiliates. Inclusion of a specific code or procedure is not a guarantee of claim payment and is not instructive as to billing and coding requirements. Coverage of a service or procedure is determined based upon the applicable member plan or benefit policy. For information about BlueCross BlueShield of Tennessee member benefits or claims, please call the number on the back of the member's ID card.

Archived editions of BlueAlert are available **online.**

Contact Us Through Availity

Availity® makes it easy for you to do business with us online anytime, offering faster prior authorizations, claims decisions and more. You can log in at **Availity.com** to:

- Check benefits, eligibility and coverage details
- Manage prior authorizations
- Enroll a provider
- Request claim status
- View fee schedules and remittance advice
- Manage your contact preferences

CAQH Solutions | PROVIEW™

Be sure your **CAQH ProView**™ profile is kept up to date at all times. We depend on this vital information.

Provider Service Lines:

Featuring "Touchtone" or "Voice Activated" Responses

Commercial Service Lines	1-800-924-7141
Monday-Friday, 8 a.m. to 6 p.m. (ET)	
Commercial UM	1-800-924-7141
Monday-Thursday, 8 a.m. to 6 p.m. (ET) Friday, 9 a.m. to 6 p.m. (ET)	
Federal Employee Program	1-800-572-1003
Monday-Friday, 8 a.m. to 6 pm. (ET)	
BlueCare	1-800-468-9736
TennCare*Select*	1-800-276-1978
CoverKids	1-800-924-7141
CHOICES	1-888-747-8955
ECF CHOICES	1-888-747-8955
Monday–Friday, 8 a.m. to 6 p.m. (ET)	
BlueCare Plus℠	1-800-299-1407
Seven days/week, 8 a.m. to 6 p.m. (ET)	
***Select*Community**	1-800-292-8196
Monday-Friday, 8 a.m. to 6 p.m. (ET)	
BlueCard	
Benefits & Eligibility	1-800-676-2583
All other inquiries	1-800-705-0391
Monday–Friday, 8 a.m. to 6 p.m. (ET)	
BlueAdvantage	1-800-924-7141
Seven days/week, 8 a.m. to 9 p.m. (ET)	
eBusiness Technical Support	
Phone: Select Option 2 at	(423) 535-5717
Email:	**eBusiness_service@bcbst.com**
Monday-Thursday, 8 a.m. to 6 p.m. (ET) Friday, 9 a.m. to 6 p.m. (ET)	

Important Note:

If you have moved, acquired an additional location, changed your status for accepting new patients, or made other changes to your practice or facility:

Please visit our payer space at **Availity.com** and update your information.

Update your provider profile on the **CAQH Provider Portal** website.

Questions? Call **1-800-924-7141**.